Professionals FAQs

These FAQs address questions often posed by clinicians.

What are open notes?

Written by doctors, nurses, therapists, or other health professionals to describe interactions with patients, notes are part of the medical record. They have various names – visit notes, clinic notes, progress notes, or chart notes, to name a few. But when patients are invited to read these notes, they become open notes.

What is OpenNotes?

OpenNotes is not a product. It's a growing international movement that gives patients easy access to open notes, and it's backed by the federal Health Insurance Portability and Accountability Act (HIPAA), which makes it well within patient's rights to review and copy their visit notes.

In 2010, 105 volunteering doctors and 20,000 of their patients completed a yearlong, multicenter trial of open notes. As part of the project, primary care clinicians invited patients to read their signed visit notes. At the end of the year, patients overwhelmingly supported the program. Doctors also saw benefits for patients and little burden for themselves. At the end of the study, both patients and doctors wanted to continue sharing notes. The findings of the trial had considerable impact, and less than 5 years after its publication, millions of patients in the US have gained ready electronic access to notes.

What are the benefits of sharing notes?

Patients who read their notes report that they:

- Have a better understanding of their health and medical conditions
- Can better recall and follow of their care plan
- Feel more in control of their health
- Take better care of themselves
- Do a better job taking their medications as prescribed
- Can communicate more clearly and end up having a better relationship with their provider

How do I find out if my doctor is using OpenNotes?

Visit Find Your Institution to see if the hospital or clinic where you doctor works shares notes.

> "Recent experience has shown that access to data and information at the point of care and the ability to analyze data for management and research purposes improve the quality and reduce the costs of care."
>
> —*FROM THE COMPUTER-BASED PATIENT RECORD: AN ESSENTIAL TECHNOLOGY FOR HEALTH CARE*

How can I get the most out of my notes?

Here are some tips for getting the most out of your notes:

- Read your notes after a visit to carefully to review what has discussed, including the care plan, medication dosages and instructions and recommendations for follow up appointments or referrals.
- Read notes between visits to remind yourself of the treatment plan and to remember upcoming procedures, tests, or appointments.
- You may decide to share your note with family, informal care partners, or others who are involved in your health. Sharing is a great way help manage care and to make sure your entire care team is on the same page.
- You can print out your note and post it on the refrigerator, for example, as a reminder or take it to a visit with another clinician on your care team.
- Before your next visit, read your note to remind yourself about your last conversation with your doctor or nurse and to prepare for your next visit. Think about the things you've done since you last saw your doctor and the questions you'd like to ask.
- When you read the note it may trigger questions or remind you of additional information potentially important for you care. Try to take appropriate action. Some issues can wait for a next visit; others are best addressed quickly.

How soon after a visit or discussion will I be able to see my note?

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What about confidentiality?

It's important for you to know that OpenNotes does not change the confidential relationship you have with your doctor. Only you and the providers directly involved in your care can access your note. What does change is *your* ability to share. With OpenNotes, it is easier to share your medical information with a care partner, family member, or others, but *only* if you choose. You are in full control of who has access to your note, which means you are in full control of your privacy.

Is it ok for me to print or email my note?

Your note is in *your* record so you should feel free to print or email it in order so share with family members, care partners, or other doctors.

What if I have questions about the information in my note?

Because your note is part of your larger medical record, it may contain medical language, abbreviations, or terminology that's not so easy to understand. A list of common abbreviations and acronyms can be found here. If you have questions about your note, write them down so you can email them to your clinician's office or share them at your next appointment, and ask your doctor or nurse for websites or other resources that might help you better understand your note.

What should I do if I have concerns about something I read in my note or think I may have found an error?

If it's a serious issue, like a potential mistake that could affect your care immediately, contact the office of the doctor who wrote the note and tell them about your concern. Be sure to write down the correction and bring it to your doctor's attention so your records can be updated. Use your best judgment about small mistakes, such as spelling or grammar. Doctors often dictate their notes and rely on others to type them. If these less immediate issues feel important, bring them up at your next visit.